HEALTH SYSTEM

OFFICE of TELEMEDICINE

April 1, 2007

Marlene H. Dortch
Secretary,
Federal Communications Commission
445 12th Street SW
Washington, D. C., 20054

RE: WC Docket No. 02-60

Dear Secretary Dortch:

The Office of Telemedicine of the University of Virginia Medical Center respectfully submits the following comments to the above captioned proceeding. We are grateful to the Commission for its efforts to expand the Rural Health Care Support Mechanism.

Sincerely,

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Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D. C. 20554

In the Matter of:

Notice of Proposed Rulemaking (NPRM) Regarding the Universal Service Support Mechanism for Rural Healthcare	WC Docket No. 02-60

Comments of the Office of Telemedicine of the University of Virginia Medical Center

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Comments of the Office of Telemedicine of the University of Virginia Medical Center

The Office of Telemedicine of the University of Virginia Medical Center (UVa) submits the following comments in response to the Commission's Notice of Proposed Rulemaking (NPRM) in the above captioned proceeding.

The Commission seeks comment on "the Petition for Reconsideration filed by the American Telemedicine Association regarding the Commission's recent Report and Order redefining rural for purposes of the Program. UVa urges the Commission to consider permanent grandfathering of those sites previously eligible for Rural Health Care Support that no longer qualify based on the 2000 census.

A. Background of respondent

The Office of Telemedicine of the University of Virginia Medical Center serves more than 60 sites through its telemedicine network serving citizens residing in rural and urban regions of the Commonwealth of Virginia. Through this network, UVa provides clinical consultative services, health professional education and patient education with the goal of enhancing access to quality care not locally available in many communities. To date

we have facilitated more than 9600 clinical encounters between remotely located patients (many of whom reside in medically underserved Appalachian communities) and our specialist physicians. We have also facilitated more than **23,000** teleradiology services and have broadcast thousands of hours of educational programs.

Since the inception of our program, our telehealth network has been deployed with a host of communications services including a statewide ATM network, T1, ISDN, DSL, frame relay, wireless, satellite and cable modem technologies with equipment that supports various video protocols such as **H.320, H.323,** and **H.324.** We have chosen to procure equipment that is both scaleable and open architecture so as to give us flexibility as to the mode of transport and connectivity within our own and to other networks. Such protocols and connectivity are entirely transparent to the end user.

B. Statutory guidance **from** the **Act:**

In the Act, Congress elucidated specific principles which serve as the basis for policy decisions regarding universal service, including:

- Section **254** (b) (2) *"Access to advanced services – Access to advanced telecommunications and information services should be provided in* ***all*** *regions of the Nation."*
- Although Section **254** (b) (6) references eligibility to advanced *telecommunications services* for purposes of schools, healthcare and libraries,
- Section **254** (b) (7) authorizes the Commission to base policies on *"Suchother principles as the Joint Board and the Commission determine are necessary and appropriate* ***for*** *the protection of the public interest, convenience, and necessity*

and are consistent with this Act."[1]

Other links between universal service, the public interest and healthcare are addressed in the Act.

- Section **254** (c) (i) (A) links universal service "*with the public health and public safety.*"[2]

The Commission is authorized in the Act to reassess the Rural Healthcare Support Mechanism based on advances in technologies and services under Section **254** (c) (i) which states *"Universal service is an evolving level of telecommunications services that the Commission shall establish periodically under this section taking into account advances in teleconimunications and information technologies and services."*

Through the report of the initial 1997 Advisory Committee on Telecommunications and Health Care, a description of eligible advanced communication services for purposes of the Rural Healthcare Support Mechanism was established. In recent years, however, significant advancements in technology and telecommunications carrier architecture has resulted in a need to modernize the eligible services and discounts associated with the Program.

We maintain that broadband facilitated access to healthcare services as provided through telehealth and other health information technologies falls within the context of the public interest, public health and public safety. We also believe that access to core health services such as may be facilitated by emergency responders connected to health providers via any form of wireless technology also falls within the context of public safety.

Thus, we argue that based on the guiding principles elucidated above, the

[1] 47 U.S.C. §254(b)(1-7)
[2] 47 U.S.C. §254(c)(1)(A)

Commission has the statutory authority to expand universal service coverage for purposes of the rural healthcare support mechanism to permanently grandfather as eligible for discounts all telehealth sites previously funded under the Program.

C. Comments re the definition of rural:

We are very grateful to the Commission for its interest and recent significant expansion of the definition of rural for purposes of the Rural Healthcare Support Mechanism.[3] The Commission, however, did not choose to define rural in accordance with the recommendations of the American Telemedicine Association or the University of Virginia in our comments. With our support, the American Telemedicine Association submitted a petition for reconsideration of the order re-defining rural for purposes of the Program in the hopes of permanently grandfathering previously eligible sites. We, like others nationwide, have identified some unexpected consequences of the new rule, including the ineligibility in 2008 of small communities such as Tazewell, Virginia, now located in the Bluefield, VA-Bluefield WVA core based statistical area. The small community hospital in the Appalachian town of Tazewell, VA (population 4100 persons) serves much of mountainous Tazewell county and is located approximately **20** miles from the nearest hospital in Bluefield, WVA. Overall the population of Tazewell County decreased from the 1990 census (45960) to the 2000 census (44598) a total decrease in population of 1362 people or over 3% of the population. This telehealth facilitated hospital will become ineligible for discounts once the 3 year period of grandfathering of previously eligible sites expires. During the three years that this healthcare provider has filed for Universal Service as a "grandfathered site no new

[3] FCC Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking Federal Register: February 7, 2005 Volume 70, Number 24

competition for broadband services has emerged in the region. If the Universal Service support were to expire the cost of sustaining the connectivity will increase over five fold from $160. per month to over $800., making the telehealth program unaffordable for the hospital in Tazewell.

A similar case can he made for the Community Health Center of Martinsville, located in Henry County. The population of Henry County taken for the 1990 census was 56940. In 2000 the census the population was 57930 an increase of just 990 people. Because of an economic downturn in the area the estimated census for 2005 was 56501 or less than the population in 1990. The unemployment rate for Henry County in 2005 was 6.6% nearly double the state of Virginia average of 6.6%. The Health Care Provider (HCP) filed for Universal Service Fund support for each year and has not received any competitive responses. Henry County was removed from the USAC list of rural sites.

We propose the Commission consider permanent grandfathering of previously funded telemedicine sites since good faith clinical decisions and investments in telehealth were made based on sustainability calculations which included rural healthcare discounts. There is precedent for such action in the Medicaid and SCHIP Benefits Improvement and Protection Act of **2000** (BIPA **2000)** wherein Congress authorized permanent grandfathering of **HRSA** funded federal telehealth grantee sites as eligible consult origination sites for purposes of Medicare reimbursement regardless **of** evolving rurality status.4

D. Conclusion:

We commend the FCC for its recent modifications of the Rural Healthcare Support Mechanism. We are hopeful that the Commission will consider this further modification

[4] 42 U.S.C. §1305 (HR 5661) Medicare. Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000

that will permanently grandfather as eligible for discounts all telehealth sites previously funded under the Program.

With the changes outlined above, with this rulemaking, the Commission has the opportunity to more fully implement the vision of the Congress and the Presidential Executive Order of 2004 to improve access to healthcare for all Americans, and to facilitate the nationwide implementation of interoperable health information technologies to reduce medical errors, improve quality, and produce greater value for our health care expenditures.

Respectfully submitted,

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Eugene Sullivan, MS
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